PRELIMINARY DRAFT

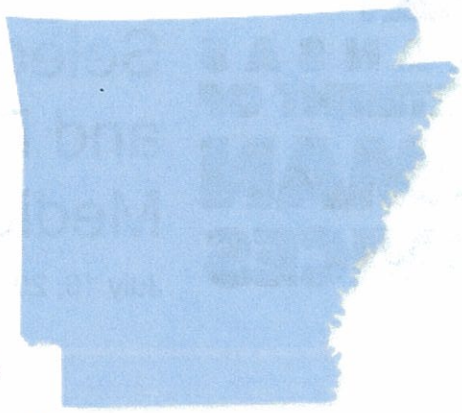
ARKANSAS DEPARTMENT OF HUMAN SERVICES

Selected facts relating to episode and PCMH impact for Arkansas Medicaid

July 16, 2015

Historically, Arkansas has faced major health care challenges

- **Arkansas has scored poorly on national health indicators**
  - The state has been ranked at or near the bottom of all states on national health indicators, such as heart disease and diabetes
- **The health care system has been hard for patients to navigate,** and has not rewarded providers who work as a team to coordinate care for patients
- Health care spending had been growing unsustainably:
  - Insurance premiums had doubled for employers and families for the past 10 years prior to beginning the initiative (adding to uninsured population)
  - Previously, Medicaid faced large projected budget shortfalls



Payers recognized the value of working together to improve our system, with close involvement from providers and other stakeholders

Coordinated multi-payer leadership…

- Creates **consistent incentives** and standardized reporting rules and tools
- Enables **change in practice** patterns as program applies to many patients
- Generates enough scale to justify investments in **new infrastructure** and operational models
- Helps **motivate patients** to play a larger role in their health and health care

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

QualChoice HEALTH INSURANCE

Arkansas Medicaid

1 Center for Medicare and Medicaid Services

In the long term, Medicaid and private insurers in Arkansas believe paying for results, not just individual services, is the best option to improve quality and control costs

This initiative aims to…

✓ Transition to payment system that **rewards value and patient health outcomes** by aligning financial incentives

This initiative <u>DOES NOT</u> aim to

✗ **Reduce payment levels for all providers** regardless of their quality of care or efficiency in managing costs

✗ **Pass growing costs on to consumers** through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)

✗ **Intensify payer intervention in decisions though managed care or elimination of** expensive services (e.g. through prior authorizations) based on restrictive guidelines

✗ **Eliminate coverage of** expensive services or eligibility

The episode-based model is designed to reward coordinated, team-based, high quality care for specific conditions or procedures

The goal	**Coordinated, team-based care** for all services related to a specific condition, procedure, or disability (e.g., pregnancy episode includes all care prenatal through delivery)
Accountability	A provider 'quarterback', or **Principal Accountable Provider** (PAP) is designated as accountable for all pre-specified services across the episode (PAP is provider in best position to influence quality and cost of care)
Incentives	**High-quality, cost-efficient care** is rewarded beyond current reimbursement, based on the PAP's average cost and total quality of care

Selected facts relating to episode impact for Arkansas Medicaid (1/2)

Episode	PAP	Direct episode spend[1], $M	Number of episodes[1]	PAP average cost variation[2], %	Related spend for PAP[3], $M	Estimated direct savings to date[4], %	Observations relating to estimated direct cost savings
Perinatal	OBGYN	87.0	19,052	18	117	2-4	▪ C-section rate reduced from 39% to 34%
URI (three episodes)[5]	PCP	13.6	180,404	40-55	Low directly; large via referrals	4-8	▪ 17% lower antibiotic prescribing rate ▪ Average episode cost flat despite ~10% increase in drug prices
ADHD (two episodes)[6]	Physician or RSPMI	39.1	9,933	201	440	15-25	▪ Average episode cost fell by 22% in first year for individuals with valid episodes in both years ▪ 400 providers in other BH dx contacted re stimulant use
Total joint replace-ment	Orthopedic surgeon	5.0	475	40	14	5-10	▪ # episodes down from 141 to 101 ▪ 30-day all-cause readmission rate decreased from 3.9% to 0% (~100 episodes); slight increases in infections (1.4% to 2.0%) / complications (6.4% to 7.9%)
CHF exacer-bation	Hospital	6.2	1,193	104	369	0-5	▪ 30-day all-cause readmission rate up from 16.0% to 19.9% (~200 episodes); slight changes in infections (7.6% to 8.5%) / observation rate (43% to 40%)

1 Spend and volume relevant to this specific episode, after business and clinical exclusions. Most recent year analyzed prior to launch
2 Difference between PAP average episode cost at 25th and 75th percentiles 3 Spend relating to potential episodes likely to have same PAP, on a "restrictive" definition of included spend. For hospitals, total is for all hospital PAP episodes; limiting to acute events only gives related spend of $189M
4 Estimated annual savings in direct average episode cost since launch, relative to baseline expectation
5 Includes three episodes: URI (unspecified), URI (pharyngitis), URI (sinusitis). Values given are total of the three or a range across the three
6 Includes level 1 and level 2

Selected facts relating to episode impact for Arkansas Medicaid (2/2)

Episode	PAP	Direct episode spend[1], $M	Number of episodes[1]	PAP average cost variation[2], %	Related spend for PAP[3], $M
Cholecystectomy	General surgeon	1.6	718	45	19
Colonoscopy	Performing physician	1.3	1,308	25	17
Tonsillectomy	ENT	2.8	2,480	8	11
DD	Physician or RSPMI	17.1	8,380[4]	64	440
CABG	Cardio-thoracic surgeon	0.9	81	31	8
Asthma exacerbation	Hospital	2.4	3,383	48	369
COPD exacerbation	Hospital	2.3	972	77	369

Total "Related spend for PAP" across all launched episodes: ~$1B

1 Spend and volume relevant to this specific episode, after business and clinical exclusions. Most recent year analyzed prior to launch
2 Difference between PAP average episode cost at 25th and 75th percentiles
3 Spend relating to potential episodes likely to have same PAP, on a "restrictive" definition of included spend. For hospitals, total is for all hospital PAP episodes; limiting to acute events only gives related spend of $189M
4 Figure not available from same source; figure shown here is approximated

In 2014 Medicaid launched a Patient Centered Medical Home (PCMH) with three primary objectives

PCMH objectives:

1.  Reduce or control the cost of care

2.  Enhance the patient experience of care

3.  Improve the health of the population

How primary care providers achieve results:

- **Care coordination** – e.g. Planning and facilitating the care of high need patients
- **Transitions of care** – e.g. Following up with a primary care visit after hospitalization
- **Practice transformation** – e.g. daily team meetings to optimize performance
- **Improved access** – e.g. creating a 24/7 telephone access for patients to reach a primary care doctor

This initiative exceeded the outlined program objectives due to the Arkansas Primary Care Providers who fully embraced the program and who excelled in making it a success

Patient Centered Medical Home (PCMH)*

- **PCMH programs have been implemented across the country to achieve three goals –** control the cost of care, enhance the patient experience of care, improve the health of the population

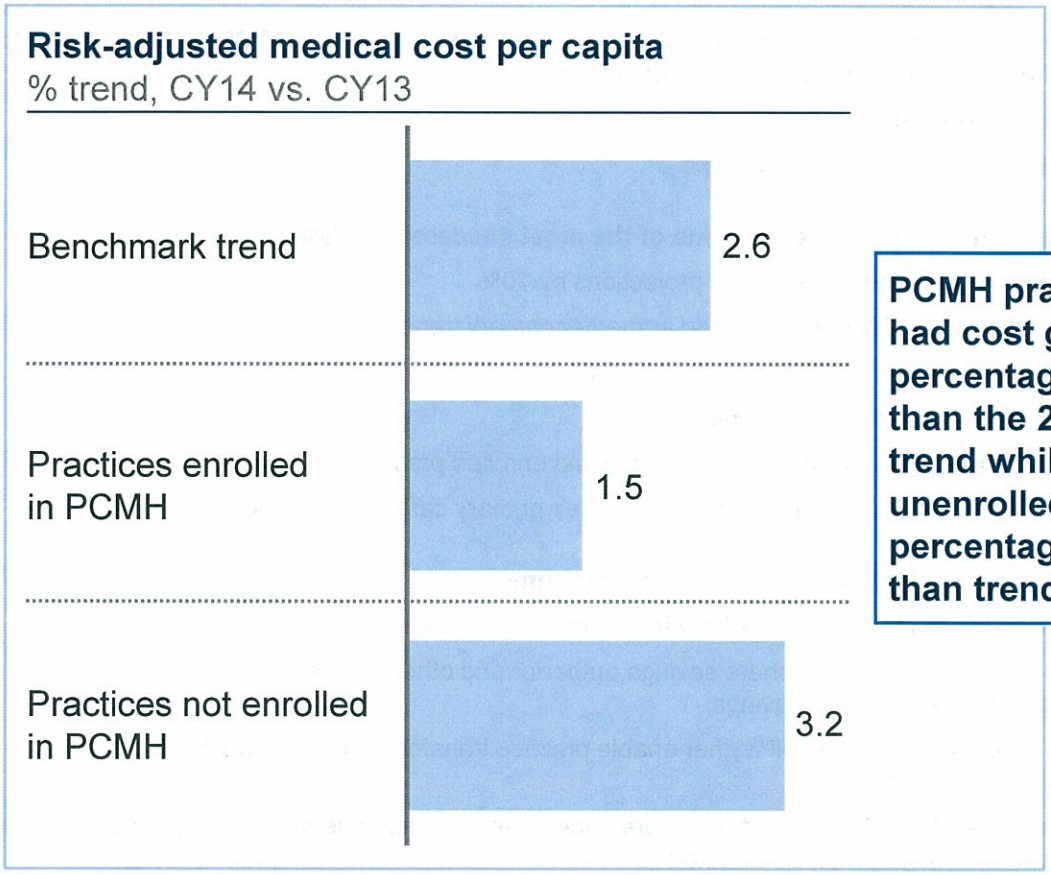
- **Industry experience demonstrates that transformation of a primary care practice to a PCMH involves significant changes to underlying behaviors, processes, and work flows resulting in**
  - Gradual ramp up of impact over a 3-5 year time period
  - Impact that extends beyond the technical PCMH scope

- **First year Arkansas PCMH results meet the bar of some of the most successful PCMHs in the industry**
  - **295k Medicaid beneficiaries,** exceeding enrollment projections by 70%
  - **$19.7M in direct Medicaid cost avoidance** compared to the benchmark trend
    - $12.1M used to fund foundational investments in primary care
    - $7.6M to be shared between the state and providers
  - **78% of quality measures improved or maintained** for Medicaid enrolled practices
  - **100% of enrolled beneficiaries with 24-7 phone access** to their primary care practice doctors

- **Evidence suggests PCMH impact will significantly increase over time**
  - **Increasing experience –** Practices further in their transformation drive greater impact
  - **Increasing incentives –** Practices eligible to share savings outperformed other enrolled practices. In year 2 all practices are eligible to participate in shared savings.
  - **Increasing investment –** Additional payors will further enable practice transformation by covering more patients and increasing investment in primary care
  - **Enhancing program design –** Medicaid will expand covered spend and will increase transparency enabling primary care providers to make cost and quality informed decisions

* Arkansas Medicaid's PCMH implementation has been especially successful because of the added participation of several commercial payors in January 2015. The following pages describe Medicaid's PCMH only

1 Practices enrolled in the medical home program had lower cost growth than both benchmark trend and their unenrolled peers



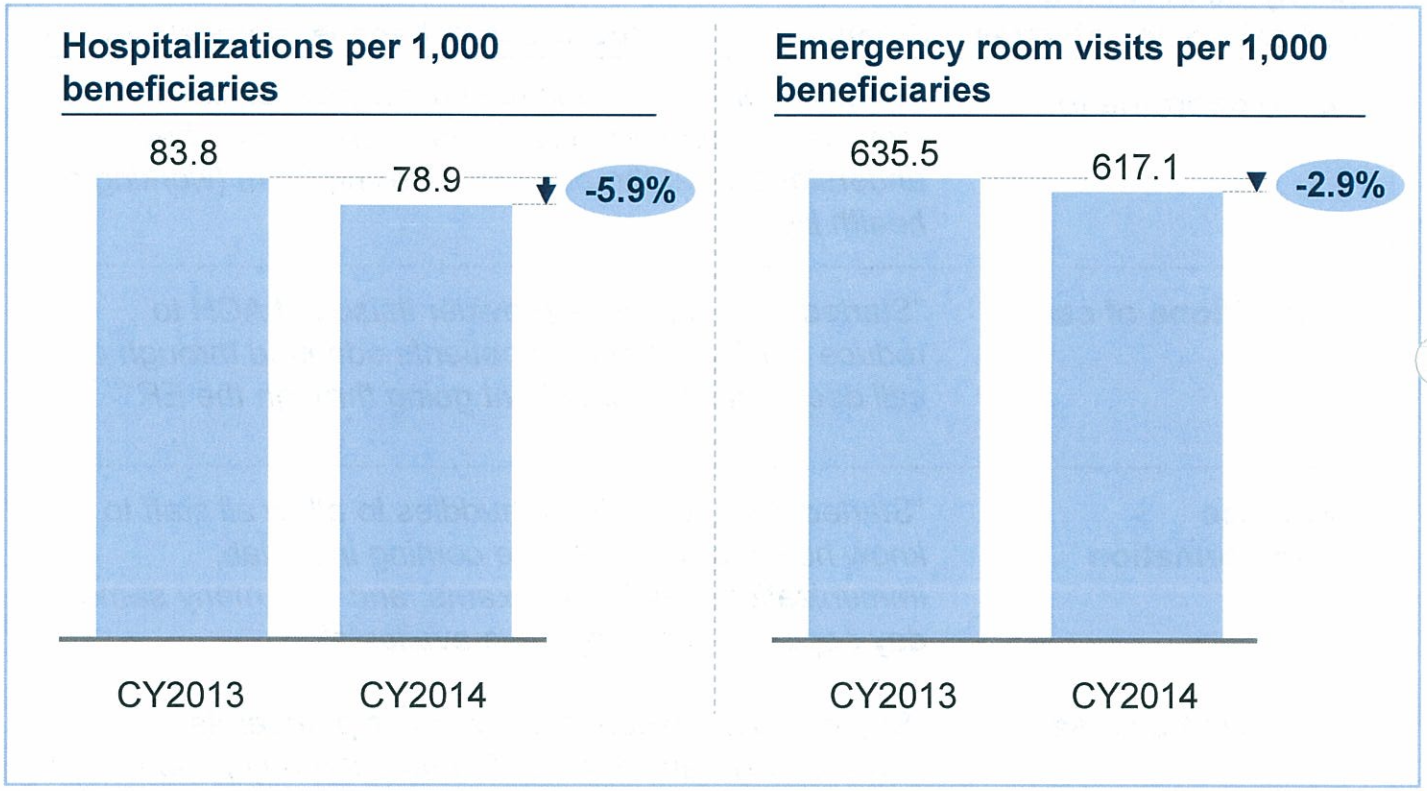
PCMH practices in 2014 had cost growth 1.1 percentage points lower than the 2.6% benchmark trend while their unenrolled peers were 0.6 percentage points higher than trend

Source: ARS tables from CY10,11,12,13,Q2'15 reports

2 Arkansas practices are required to change the way they operate in order to maintain eligibility for the medical home program

Examples of Arkansas medical home activities	Comments from doctors in Arkansas medical homes
▪ **Care coordination**	*"PCMH coordinator joins high priority beneficiaries when they are meeting with providers to make sure they understand what the provider is telling them (working on health literacy)"*
▪ **Transitions of care**	*"Started working with a provider liaison at ACH to reduce barriers of getting patients admitted through on call doctor instead of patient going through the ER"*
▪ **Practice transformation**	*"Started doing daily team huddles to allow all staff to know how many people are coming in for lab, immunizations, wellness exams, and how many same day appointments they have available"*
▪ **Improved access**	*"Started doing patient surveys to help understand barriers they have to care. Found out many patients did not realize they had after-hours care so started including it on hold messages and handouts"*

3 Reductions in hospitalizations and emergency room visits are leading indicators of both improved primary care quality and lower costs



Source: ARS tables from CY10,11,12,13,Q2'15 reports